



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

HOUSTON PAIN & INJURY  
604 PENNY LANE  
FRIENDSWOOD TEXAS 77546

DWC Claim #:  
Injured Employee:  
Date of Injury:  
Employer Name:  
Insurance Carrier #:

#### **Respondent Name**

METROPOLITAN TRANSIT AUTHORITY

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-11-0917-01

#### **MFDR Date Received**

November 12, 2010

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "All timed codes accounted for in documentation."

**Amount in Dispute:** \$1,260.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The Requestor is specifically requesting dispute resolution for CPT code 97110 – Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises. The requestor billed for 6 units of 97110 in the amount of \$216.00 for each of the service dates listed above. One unit of 97110 was recommended for payment, per day, in the amount of \$38.00. The other 5 units were denied as documentation did not support time spent. Please note that 1 unit of CPT code 97140 – Manual therapy techniques, one or more regions, each 15 minutes, was also billed and paid at fee schedule. As well as an untimed CPT code 97150 – Therapeutic procedure(s) group was billed and paid for at fee schedule. The Medical Fee Guidelines, rule 134.203, which, with some exceptions, uses the most current reimbursement methodologies, models, and values or weights used by the Centers for Medicare and Medicaid (CMS), including applicable payment policies relating to coding, billing, and reporting. For codes that are defined as per 15 minutes or each 15 minutes, Medicare would not expect to see the qualified professional billing per treatment site. Report these codes based on the actual amount of time spent on a cumulative basis for the specified modality or procedure."

**Response Submitted by:** STARR Comprehensive Solutions, Inc.

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 6, 2010 through August 23, 2010	97110	\$1,260.00	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

## **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline reimbursement for professional services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated September 7, 2010

- 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.

Explanation of benefits dated October 18, 2010

- 150 – Payment adjusted because the payer deems the information submitted does not support his level of service.
- 150 – Physical medicine rules require that all timed modalities be supported with timed documentation. Active rehab exercise for l-spine reports 8 min for ube and 15 min bike.
- 193 – Original payment decision is being maintained. This claim was processed properly the first time.

## **Issues**

1. Did the requester document the time for procedure code 97110?
2. Is the requestor entitled to reimbursement?

## **Findings**

1. 28 Texas Administrative Code §134.203 states in pertinent part “(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.”
  - CPT code 97110 is reimbursement at 15 minute increments. CMS requires that the total treatment minutes, including those minutes of active treatment reported under the timed codes and those minutes represented by the untimed codes, must be documented.
  - Review of the submitted documentation and supplemental documentation submitted on February 16, 2011 documents one unit of CPT code 97110 for each date of service in dispute. The insurance carrier reimbursed the requestor one unit of CPT code 97110.
  - The requestor has not submitted sufficient documentation to support reimbursement for the additional 5 units billed for each date of service. Therefore reimbursement cannot be recommended for 5 units of CPT code 97110 for dates of service August 6, 2010, August 11, 2010, August 13, 2010, August 16, 2010, August 18, 2010, August 20, 2010 and August 23, 2010.

## **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### Authorized Signature

_____	_____	May 23, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**